Department of Health
Office of Emergency Medical Services & Trauma System

SERVICE / VEHICLE LICENSURE APPLICATION

☐ New ☐ Amendment

Service Name: _____ / _____
(Legal Name) *(Also Known As)*

Address: _____ EMS Agency/License #: _____
(If known)

_____

City: _____ State: _____ Zip: _____

Owner/Operator: _____ Phone: _____

EMS Representative: _____ Phone: _____

E-Mail Address: _____ FAX: _____

LICENSE TYPE * (check only one): Ambulance (Transport) ☐ Aid Vehicle (Non-Transport) ☐

*** If your agency is seeking Trauma Verification, please contact our office for the appropriate forms.**

ORGANIZATION TYPE: (check the one that ***best*** applies to your organization)

Private for profit	☐	Fire District	☐	Law Enforcement	☐
Private non-profit	☐	City Fire Dept.	☐	Municipal (city/county)	☐
Private volunteer association	☐	Industrial Fire Dept.	☐	Search & Rescue	☐
Hospital District	☐	City/Fire Dist. Comb	☐	Other (*please specify below*)	☐
EMS District	☐	Federal Fire Dept.	☐	_____	

VEHICLES: Please provide the **number** of each vehicle type you are licensing (see Page 2):

Ambulance (Transport) ☐ Aid Vehicle (Non-Transport) ☐

RESPONSE INFO: Please provide the **number** for each EMS activity listed below, for your last full calendar year (*if applicable, i.e. when changing the existing type of service. First time applicants need not provide this information*)**:**

Primary Responses ☐ Transports Primary/Secondary ☐
Secondary Responses ☐ Interfacility Transports *Only* ☐

PERSONNEL STATUS: Are your EMS personnel primarily: (*check one*) Paid ☐ Volunteer ☐
Number of EMS personnel (Page 3) that are: Paid ☐ Volunteer ☐

DO NOT DUPLICATE

SERVICE / VEHICLE LICENSURE APPLICATION
EMERGENCY MEDICAL *VEHICLES*

Please provide the following information for all vehicles to be licensed. Vehicle location is the **address** in which the vehicle is ***physically located.*** Indicate the *type* of vehicle(s): AMB = ambulance; AID = aid vehicle (as defined in RCW 18.73.030). **Please check to see that each licensed vehicle has a license sticker appropriately displayed in the window. If there is no sticker, request one below.**

Please review WAC 246-976-260 through 340 to ensure your vehicles meet all requirements. WAC 246-976-300 requires all licensed vehicles to carry extrication equipment. A variance from this requirement may be requested, and if approved, the extrication equipment must be available within 10 minutes. To request a variance, indicate the **name** of the agency(s) providing extrication equipment below and enter 'Yes' next to the appropriate vehicles.

YOUR SERVICE NAME: _____

Agency(s) providing extrication equipment: _____

	YEAR	MAKE AND MODEL	LICENSE PLATE NUMBER	ACTUAL ADDRESS OF VEHICLE *(If Different From Page 1)*	Choose One (✓)		STICKER NEEDED (Yes or No)	VARIANCE *For Extrication Equipment* (Yes or No)
					AMB	AID		
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Attach additional sheets as necessary, including all the required information.

NOTE: When *adding*, *removing*, or *changing* the location of licensed vehicles, it is always necessary to notify the Department of Health of the change(s). Contact the licensing office, at the address or telephone number below, to request a **"VEHICLE CHANGES APPLICATION."**

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SERVICE / VEHICLE LICENSURE APPLICATION
EMERGENCY MEDICAL *PERSONNEL*

List all personnel who will be providing emergency care with your organization, showing their EMS certification level (First Responder through Paramedic as identified in RCW 18.73). Include all EMS personnel who are full or part-time, paid or unpaid.

NOTE: This list DOES NOT automatically associate personnel with your agency. All EMS personnel must possess a current Washington State certification card to provide EMS care.

PLEASE KEEP A COPY OF THIS LIST ON FILE FOR INSPECTION BY THE DEPARTMENT OF HEALTH.

SERVICE NAME: _____

	NAME / REGISTRY #	*AFA	FR	EMT	IV TECH	AW TECH	IV/AW TECH	ILS TECH	ILS/AW TECH	PM
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
PLEASE TOTAL EACH COLUMN:										

Attach additional sheets as necessary, including all the required information.

Legend:

***AFA** = Advanced First Aid
FR = First Responder
EMT = Emergency Medical Technician
IV TECH = Intravenous Therapy
AW TECH = Airway Technician
IV/AW TECH = IV & Airway
ILS TECH = Intermediate Life Support
ILS/AW TECH = ILS & Airway
PM = Paramedic

* Advanced First Aid is not a level of certification regulated by the Department of Health.

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SERVICE / VEHICLE LICENSURE APPLICATION
GENERAL OPERATION

Please describe the **general operation** of your service; including how it will operate in a manner consistent with WAC 246-976, the Regional Plan, and approved Regional Patient Care Procedures. *(Please find this information on our website at **www.doh.wa.gov/hsqa/emstrauma** **click on "Licensure Processes."** If you need hard copies of this information, please contact the Licensing and Certification office, shown at the bottom of this application).* Provide an explanation of your:

1. **Dispatch plan**

2. **Response plan**

3. **Response area**

4. **Type of transport (emergency and/or interfacility), if any**

5. **Tiered response and rendezvous, if any**

6. **Back-up plan to respond (may not apply to agencies doing interfacility transports only)**

NOTE: Other services involved in your response plan must be informed by you that they are participants and must agree to that participation. Attach extra sheets as necessary.

"I hereby affirm and declare that the information provided on this application is true and correct, and that:

1. *We operate in a manner that is consistent with the Regional Plan and pre-hospital patient care procedures;*
2. *The vehicles identified on Page 2 meet the minimum equipment requirements for the type of licensure requested by our service;*
3. *We meet the minimum staffing requirements for licensure as identified on Page 3;*
4. *Our certified EMS personnel utilize DOH approved Medical Program Director (MPD) protocols; and*
5. *We maintain current liability insurance coverage (copy attached)."*

Person Completing Application ***(Please Print)*** **Date**

Owner/Operator ***(Signature & Title)*** **Date**

DO NOT DUPLICATE